ATTACHMENT 7a

MAPB-087-016-D
Date: 9/1/87

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

# PA/TA

## THERAPY ATTACHMENT

(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

### RECIPIENT INFORMATION

| ① LAST NAME | ② FIRST NAME | ③ MIDDLE INITIAL | ④ MEDICAL ASSISTANCE ID NUMBER | ⑤ AGE |
|---|---|---|---|---|
| RECIPIENT | IM | A | 123456789Ø | 29 |

### PROVIDER INFORMATION

| ⑥ THERAPIST'S NAME AND CREDENTIALS | ⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER | ⑧ THERAPIST'S TELEPHONE NUMBER |
|---|---|---|
| I.M. PERFORMING, PT. | 12345678 | ( XXX ) XXX - XXXX |

⑨ REFERRING/PRESCRIBING PHYSICIAN'S NAME: I.M. REFERRING/PRESCRIBING

A. Requesting: ☒ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

B. Total time per day requested: 30 min.
Total Sessions per week requested: 3
Total number of weeks requested: 26

C. Provide a description of the recipient's diagnosis and problems and date of onset.

R CVA 12-27-86
HYSTERECTOMY 2° TO ADENOCARCINOMA - 1986
ADULT ONSET DIABETES - SEVERAL YRS DURATION
CHF-SEVERAL YEARS DURATION

D. BRIEF PERTINENT HISTORY:

PT WAS ADMITTED 1-12-87 AFTER HOSPITALIZATION FOR ACUTE CVA 12-27-86. HOSPITALIZED FROM 3-6-87 TO 3-12-87 FOR PNEUMONIA. HAS BEEN MEDICALLY STABLE AND ALERT SINCE RETURN ON 3-12-87.

E. Therapy History

| | Location | Date | Problem Treated |
|---|---|---|---|
| PT | HOSPITAL | 1-2-87 to 1-11-87 | CVA |
| | NURSING HOME | 1-13-87 to 3-4-87 | CVA |
| | | 3-14-87 to PRESENT | |

OT

N/A

SP

N/A

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation).

| | 1-13-87 | 3-14-87 |
|---|---|---|
| ORIENTATION | A & O X3 | A & O X 3 |
| ROM | WFL EXCEPT<br>(L) SHLDR FLEX 140%<br>ABD 140%<br>ER 45%<br>(L) KNEE EXT -10% | WFL EXCEPT<br>(L) SHLDR FLEX 110%<br>ABD 110%<br>ER 45%<br>(L) KNEE EXT -15%<br>(L) ANKLE DORSI -10% |
| STRENGTH | (R) EXTREMITIES IN G RANGE<br>(L) UE FLACCID<br>(L) LE HIP & KNEE P RANGE<br>ANDKLE 0 | (R) U & L E F+ TO G-<br>(L) UE NON-FUNC C MODERATE FLEXION SPACTICITY PRESENT<br>(L) LE HIP & KNEE F<br>ANKLE TRACE |
| TRANSFERS | STNDG PIVOT REQUIRES MAX OF 2 | SPT MOD OF 1 |
| ELEVATIONS | SUPINE ↔ SIT MAX OF 1<br>SIT ↔ STAND MAX OF 2 | SUPINE ↔ SIT MIN OF 1<br>SIT ↔ STAND MOD OF 1 |
| AMB | NON-AMB | IN 11 BARS OF 10'x2 REQUIRES MAX OF 1 ABLE TO ADVANCE L LE INDEP 70% of TIME |
| SITTING BALANCE | UNSUPPORTED REQUIRES MAX OF 1 | UNSUPPORTED INDEP X 60 SEC IF UNCHALLENGED |

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

6-18-87

ORIENTATION 0

ROM MAINTAINED C IN (L) KNEE EXT TO -5 & (L) ANKLE DORSIFLEX TO NEUTRAL

STRENGTH (R) U & LE G TO G+ (L) UE NON-FUNC (L) LE HIP & KNEE F+ TO G- ANKLE P RANGE AFO OBTAINED 5-15-87 TO ASSIST IN TRANSFER/GAIT

TRANSFERS STNDY PIVOT C GUARDED TO MIN OF 1 IN PT & ON UNIT

ELEVATIONS SUPINE ↔ SIT ↔ STAND C GUARDED TO MIN OF 1

AMB USES HEMIWALKER C MIN ASSIST OF 1 FOR 10' x2. AMB x1/DAY ON NURSING UNIT FOR 40'.

SITTING BALANCE ABLE TO ACCEPT MODERATE CHALLENGES AND MAINTAIN BALANCE INDEP

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

| | GOALS STG | PROCEDURES |
|---|---|---|
| 1. | AMB C HEMIWALKER C<br>STANDBY ASSIST OF 1 120' x 2 | GAIT TRAINING<br>THERAPUTIC EXERCISE |
| 2. | INDEP ELEVATIONS | MAT PROGRAM |
| 3. | SPT C STANDBY ASSIST OF 1 | FOLLOW THROUGH OF PROGRAM<br>C NURSING |
| | LTG<br>INDEP IN ALL MOBILITY<br>RETURN TO INDEP LIVING | |

I. Rehabilitation Potential:

VERY GOOD POTENTIAL TO MEET ABOVE GOALS. PT HAS PROGRESS STEADILY C SHORT PERIOD OF DECLINE IN MARCH ONLY.

**THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).**

J. L. M. Prescribing
Signature of Prescribing Physician
(A copy of the Physician's order sheet is acceptable)

MM/DD/YY
Date

L. M. Performing
Signature of Therapist Providing Treatment

MM/DD/YY
Date